DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TX 78234-6000

REPLY TO
ATTENTION OF

MCCG

25 JUN 2007

MEMORANDUM FOR

Commanders, MEDCOM MAJOR SUBORDINATE COMMANDS
Directors, OTSG/MEDCOM ONESTAFF

SUBJECT: Behavioral Health Resources

1. Enclosed is a message from the new Assistant Secretary of Defense for Health Affairs, S. Ward Casscells, on recognizing and caring for Soldiers with depression. Please distribute this message widely throughout your organization. This message is also available on the Health Affairs Organization website at http://www.ha.osd.mil/asd/20070426.cfm.

2. The ASD(HA) message on mental health perspectives is part of a widespread effort to encourage identification and care for those dealing with psychological stresses of war.

3. I also encourage you to refer your Soldiers and their Families to our new website which outlines a range of resources at www.behavioralhealth.army.mil. Additionally, I have enclosed a comprehensive information paper, subject: Army Behavioral Health Programs and Initiatives, 31 May 2007, for your reference.

4. Point of contact for this memorandum is COL Elspeth C. Ritchie, Director, Proponency Office for Behavioral Health, Health Policy and Services Directorate, (703) 681-1975, or elspeth.ritchie@us.army.mil.

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GALE S. POLLOCK
Major General
Commanding

Source: http://www.ha.osd.mil/asd/20070426.cfm

From the desk of the Assistant Secretary...

Mental Health Perspectives

Hang onto this list. It could prove life-saving: What did Abraham Lincoln, Martin Luther, Winston Churchill, and General George Patton have in common with authors Tolstoy, Dickens, Twain, Faulkner and Hemingway? And with artist Van Gogh, poet Keats, and composer Beethoven? Or NFL great Terry Bradshaw, and astronaut Buzz Aldrin? Or singers John Lennon and Billy Joel, or actor Harrison Ford?

The answer is ***depression***.

There are various types of depression: with or without anxiety; with or without manic episodes; mild, moderate or severe; inherited or caused by illness, head injury, or drugs (including alcohol); or triggered by stressful circumstances like divorce, problems at work, or illness or death of a loved one.

Clinical depression affects all aspects of your life, making it difficult to perform effectively at work and at home, sleep, eat, and appreciate the songs of birds, the fragrance of flowers, Letterman and Leno. Too often the affected person may not know what label to attach to their despair or may not know that treatment is available and effective. Instead they continue, by themselves, to try to struggle along at work or at home, sometimes with disastrous consequences. While some types of depression may clear up on their own; in the meantime, the individual and the family suffer needlessly. Counseling or treatment can improve the situation more quickly and effectively.

I wish I had known all that when I was a student who got blue and grouchy during dark New England winters (but never again once I moved to the sunbelt).

Or when training to deploy to Iraq last summer. I began to think about what it would mean to my family if I didn't make it back. And when the pre-deployment training included the video on how to survive being a hostage, I very much wanted to be home, not headed for the sand. Here's what I wrote in my journal: " so tired; read one paragraph of Time's, "Life in Hell," then just as I fell asleep I woke up thinking about being tortured. Dry throat, breathing fast...got up and paced all night...Afraid I will back out. What a disgrace that would be, to the uniform and to the family."

No one else at Ft Bliss seemed to have the slightest worries about going. But I guess I didn't look it either. I say that because a senior officer confided her own concerns, so I did the same, and we agreed to talk each other onto the plane and all the way to Iraq. And we did. It helped us to help each other.

That's why I am writing this personally...to do what I can to take some of the stigma out of asking for help. It is your duty, just like getting the anthrax and flu shots. You protect yourself

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and protect others too. You can still get promoted and, in most cases, keep your security clearance.

Here at Health Affairs we are waiting for expert reports from the DoD Suicide Prevention and Risk Reduction Committee, from the MHAT-IV study of mental health of soldiers and Marines in Iraq, led by COL Carl Castro, the DoD Task Force on Mental Health co-chaired by VADM Don Arthur, and the DoD/VA Mental Health Working Group. If there are better ways to detect those at risk, or better ways to help, we will do so.

Meanwhile we must do what we can. Few of us are psychiatrists or psychologists, but all of us can watch out for our colleagues, our battle buddies. Has he or she begun to look worried or sad? Irritable or prone to anger? Talking about death? Drinking heavily? Making mistakes at work?

If so, why not say, "You don't seem like yourself lately. What's up?" If they won't talk, and things don't improve, tell him or her you are getting them help through the chain of command. If he or she gives you an opening, ask "How can I help? We need you. We care about you. So does your family"

Readily available help depends on your situation. It could include rest, support from friends and family, counseling by the chaplain, psychologist, or psychiatrist, exercise, sunshine, avoidance of certain drugs and alcohol, and the firm assurance that things will get better.

Many are already engaged in this effort, and it is important to make it clear that, despite the pressures of a long war, with family separations, and many injuries and deaths, our soldiers, sailors, Marines and airmen still have lower rates of suicide and homicide than their civilian peers. But even one is too many!

If you are a commander, or a doctor or nurse, consider posting links to these websites: http://www.ha.osd.mil/asd/www.militarymentalhealth.org; http://www.ha.osd.mil/asd/www.battlemind.org; http://www.ha.osd.mil/asd/www.pdhealth.mil/mhsa.asp; http://www.ha.osd.mil/asd/www.militaryonesource.com; and the posters made by the Army's Center for Health Promotion and Preventive Medicine led by BG Mike Cates (http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx) which drive home the message that to not seek help is to accept defeat, and that to fail to get help for your buddy is like leaving a fallen comrade. Important sources of information also include the Leaders Guides to Personnel in Distress for Air Force at http://www.pdhealth.mil/wingman_program.asp or Marine Corps http://www.ha.osd.mil/asd/www.usmc-mccs.org/leadersguide or Navy at www-wwwnehc.med.navy.mil/LGuide.

If you are depressed or anxious, get the help you need and deserve. Maybe you too will go on to greatness like Churchill or Lincoln or Patton. At a minimum you will set an example for others, who will see that you have the courage to seek help. If you identify and help a buddy in need you may save a whole family, or many more, by the good that he or she will go on to do. Thanks for your caring support!

And if you are the commander, first sergeant, or medical officer looking out for your company, wing, ship, or brigade, may it be said of you, "A great leader: first out of the foxhole, last in the chow line, and first to lend a hand."

INFORMATION PAPER

DASG-HSZ
18 June 2007

SUBJECT: Army Behavioral Health Programs and Initiatives

1. Purpose. To provide information on the Army behavioral health programs and initiatives.

2. Facts. The Army is committed to ensuring all returning veterans receive the behavioral healthcare they need. An extensive array of mental health services has long been available. Since 9/11, the Army has augmented behavioral health services and Post Traumatic Stress Disorder (PTSD) counseling, especially at the power projection platforms. We have a wide array of new initiatives to provide education and training, including "Battlemind", updated Combat and Operational Stress Control (COSC), and Provider Resiliency Training (PRT). A new program, Respect.mil, integrates behavioral healthcare and primary care. We anticipate a continued high demand for behavioral health services from Soldiers and their Families, and are committed to respond to that demand.

3. Key Points.

- Historically and today, PTSD is the most common and predictable mental health problem as a result of exposure to war and terrorism. Unsurprisingly, as the Global War on Terrorism has continued, the number of cases of post-traumatic stress disorder has increased.

- PTSD is one of a range of deployment-related psychological effects of war. Most combat veterans will have some of the symptoms of PTSD for weeks to months after their return, and perhaps fleetingly for the rest of their lives. Deployment also causes stress on marriages, families and other relationships.

- The Army recognizes the significant impact of war experiences on Soldiers. A wide range of behavioral health services is available in the Army, including screening for PTSD and appropriate referrals for care. However, especially at our large power projection platforms, which are sometimes in rural and remote locations, the wait for services may be longer than is optimal.

- The military has implemented the Post-Deployment Health Reassessment (PDHRA) to identify and refer for intervention those Soldiers at risk for PTSD and other mental health effects of war. We are offering other new training and programs, such as "Battlemind", Provider Resiliency Training, and Respect.mil.

- It is critically important to provide behavioral health services for Families. The extensions caused by the surge will put further strain on those affected. We will apply Lessons Learned from other extensions to this situation.

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4. Background:

- Definition of PTSD. There are formal diagnostic criteria for PTSD. In brief, the diagnostic criteria include: (1) exposure to a traumatic event; (2) trauma re-experienced in one of a number of ways, including dreams and flashbacks; (3) persistent avoidance of traumatic stimuli; (4) increased arousal; and (5) duration longer than one month. There are other psychological effects of war, especially difficulty reintegrating with families and society.

- COSC. There has been a robust combat and operational stress control presence in theater since the beginning of the war, with over 200 deployed behavioral health providers to Iraq alone. Mental health advisory team (MHAT) reports have demonstrated the success of these efforts. Training of providers in COSC has been updated.

- Research from The Walter Reed Army Institute of Research (WRAIR) and the MHATs of Soldiers deployed during Operation Iraqi Freedom showed that approximately 15% have PTSD and another 10 to 15% percent will experience other behavioral health problems that could benefit from treatment. As a result of the Army's research, we have implemented new programs such as "Battlemind" and Respect.mil.

- Post-Deployment Health Assessment (PDHA). Soldiers redeploying from the theater of operations are required to complete the PDHA (DD Form 2796) before leaving theater. The DD Form 2796 screens for PTSD, Major Depression, concerns about family issues, and concerns about drug and alcohol abuse. The primary care provider reviews the form, interviews the Soldier as required, and refers the Soldier to a behavioral healthcare provider as required. The primary care provider may make referrals to on-site counselors or to military treatment facilities.

- PDHRA. The PDHRA screening program is now offered to all AC and RC Soldiers deployed to a combat zone at 90 to 180 days post-deployment. There have been over 140,000 screenings performed. If following these assessments there are identified healthcare needs, Soldiers will receive care from military medical treatment facilities, VA medical centers or VET centers, private healthcare providers through TRICARE, or from Community-Based Healthcare Organizations (CBHCO) established by the Army.
- Respect.mil is a new program designed to decrease stigma and improve access to care by providing behavioral healthcare in primary care settings. The pilot test at Ft. Bragg was successful and the Respect.mil program is being implemented this year in fifteen other Army locations.
- "Battlemind". Numerous Battlemind products are in the process of development and/or have been implemented. These are training products designed to enhance

recovery and resiliency. The Post-Deployment and Spouses Battlemind are available at www.battlemind.org. New trainings and videos are in development.

- PRT. The stress of war and high operational tempo have affected medical personnel, to include psychologists. Another new program, Provider Resiliency Training, focuses on the mitigation of those stresses. PRT is now offered to all Army medical personnel and chaplains, to include those in the Reserve Components.
- Updates in Education and Training of Behavioral Health Providers. The MHATs revealed that some providers did not feel trained in combat and operational stress control issues. The COSC course was revised and expanded. It was offered in August 2006 and February 2007, and will be offered again in June 2007. The plan is for all deploying behavioral health providers to receive the course or receive equivalent training from mobile training teams.
- Past Fragmentation of Behavioral Health Initiatives in the Army. We recognize fragmentation and duplication of effort among different agencies and on installations. Implementation of The Proponency Office for Behavioral Health began on 1 March 2007, which will coordinate and integrate Army behavioral health efforts. The Proponency Office for Behavioral Health also launched a new AMEDD Suicide Prevention Office and Behavioral Health website on 1 March 2007.
- Availability of Behavioral Health Providers. There is a shortage of behavioral health providers, especially at the more remote installations (e.g., Alaska, Ft. Hood, Ft. Drum, Germany). There have been numerous efforts to hire civilians as GS employees or as contractors to help backfill deployed providers. However there is a national shortage of behavioral health providers and hiring efforts have been met with mixed success. There is also an ongoing effort to increase the recruiting and retention of uniformed providers.
- Army Behavioral Health Business Case Analysis. The AMEDD commissioned a Business Case Analysis of Behavioral Health on an installation basis, completed in March 2007. The AMEDD has reviewed and prioritized these recommendations and will implement changes as required. Recruitment and retention of providers is one of the top priorities.
- Suicide Prevention. There has been a concerted effort to improve suicide prevention throughout the Army. The MEDCOM, G-1, chaplains, and the Family Morale Welfare and Recreation Command have been coordinating education and training efforts. The Army Suicide Event Report system is continuing to offer surveillance and analysis. The AMEDD stood up a new Suicide Prevention Office on 1 March 2007 to translate the results of the ASERs into further education and training for behavioral health practitioners, leaders, Soldiers and their Families. One of the first tasks is to develop a "tactical" suicide prevention program, focusing on the theater of operations.
- Telepsychiatry. The North Atlantic Regional Medical Command (NARMC) has a very *robust* telepsychiatry program, which has been especially helpful in treating

child and adolescent patients at remote locations, where there is a shortage of child psychiatrists. We are researching the viability of expanding telepsychiatry locations into other locations especially remote locations.

- Psychological Care of the Wounded. There are numerous programs to provide for psychological care of the wounded. Walter Reed Army Medical Center has a comprehensive program, for example. We have recently re-examined the needs in the CBHCOs and Medical Holds and Holdovers (MH/MHOs). Although they do have social workers to help with screening, a full spectrum of robust behavioral health assets was often lacking. We are moving to address these needs.
- Traumatic Brain Injury (TBI). There are numerous updates in screening, education and treatment of traumatic brain injury. An ALARACT was sent to the theater last summer to alert providers to the need to screen Soldiers who had been involved in blasts or firefights. The Defense and Veterans Brain Injury Center (DVBIC) developed new guidelines for the screening and treatment of mild TBI in November 2006. These guidelines have been disseminated to medical and behavioral health providers. We will incorporate questions pertaining to TBI into the PDHA, PDHRA and PHA (Periodic Health Assessment).
- Family Assistance Centers. There are Family Assistance Centers that are located at the various MEDCENs that provide assistance to wounded Soldiers and their Families in the form of referrals to resources like Army One Source, Army Community Services, Finance and Lodging.

COL Ritchie/(703) 681-1975

Approved by: COL Cordts